MCM EMERGENCY MEDICAL AUTHORIZATION FORM

CHILD INFORMATION			
Child's Last Name:	First Name	Date of Birth:	Sex: □ F □ M
Address:		Home Phone:	
Chronic Physical Problems/Pertinent Developmental Information/Special Accommodations Needed:			

PARENT(S)/GUARDIAN(S) INFORMATION		
Father:	Cell Phone:	Email:
Address:		Home Phone:
Employer:		Work Phone:
Mother:	Cell Phone:	Email:
Address:		Home Phone:
Employer:		Work Phone:
Person(s) or Agency With Legal Custody of the Child:		

EMERGENCY INFORMATION		
Allergies or Intolerance to Food, Medication, etc., and Actions to Be Taken in an Emergency:		
Insurance Company:	Insurance Policy ID:	
Child's Physician's Address:		Phone:
Emergency Contact #1: Name:	Address:	Cell Phone: Home phone:
Emergency Contact #2: Name:	Address:	Cell Phone: Home phone:
Person(s) Authorized To Pick Up the Child:		
Person(s) NOT Authorized To Pick Up Child*		

We hereby authorize MCM personnel to take whatever steps may be necessary to obtain emergency medical care for my child in the event of an emergency. The hospital and it's medical staff have my authorization to provide any treatment which a physician deems necessary for the well being of my child. These steps may include, but are not limited to the following:

- Attempt to contact a parent or guardian
- Attempt to contact the child's physician
- Attempt to contact any of the persons on the child's emergency contact information form
- To transport my child to the appropriate medical facility , if necessary

Parents Signature: _____ Date: _____

Parents Signature: _____ Date: _____